		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005009

Facility Name: Sunny Acres Nursing Home

Address: R. R. 3 (Number) Petersburg (City) 62675 (Zip Code)

County: Menard

Telephone Number: 217-632-2334 **Fax #** 217-632-2774

IDPA ID Number: 37-6005977001

Date of Initial License for Current Owners: 1966

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	x	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	x	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mrs. Marjorie Moritz **Telephone Number:** 217-632-2334

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12-01-00 to 11-30-01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Marjorie Moritz
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Michael J. Feriozzi, CPA
(Firm Name & Address) Michael J. Feriozzi, CPA, 1316 S. Glenwood Avenue Spring field, Illinois
(Telephone) 217-522-8689 Fax # 217-632-2774

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,533	19,184		37,717	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,533	19,184		37,717	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.49%

D. How many bed-hold days during this year were paid by Public Aid?
30 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [n/a] NO [n/a]

Tax Year: n/a Fiscal Year: November 30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	252,590	20,136	597	273,323		273,323		273,323			1
2	Food Purchase		203,271		203,271	(20,296)	182,975	(13,281)	169,694			2
3	Housekeeping	155,947	35,283		191,230		191,230		191,230			3
4	Laundry	56,293	6,332		62,625		62,625		62,625			4
5	Heat and Other Utilities			120,678	120,678		120,678		120,678			5
6	Maintenance	41,843	52,422	1,650	95,915		95,915		95,915			6
7	Other (specify):*											7
8	**TOTAL General Services**	506,673	317,444	122,925	947,042	(20,296)	926,746	(13,281)	913,465			8
	B. Health Care and Programs											
9	Medical Director			6,177	6,177		6,177		6,177			9
10	Nursing and Medical Records	1,310,329	107,018	29,645	1,446,992		1,446,992	(24,861)	1,422,131			10
10a	Therapy	55,490	2,500	469	58,459		58,459		58,459			10a
11	Activities	81,469	1,500	7,592	90,561		90,561		90,561			11
12	Social Services	81,877	1,500	1,836	85,213		85,213		85,213			12
13	Nurse Aide Training		1,125	6,205	7,330		7,330		7,330			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,529,165	113,643	51,924	1,694,732		1,694,732	(24,861)	1,669,871			16
	C. General Administration											
17	Administrative	109,412	4,691	6,789	120,892		120,892	(6,789)	114,103			17
18	Directors Fees											18
19	Professional Services			26,345	26,345		26,345		26,345			19
20	Dues, Fees, Subscriptions & Promotions			14,154	14,154	6,600	20,754	(7,122)	13,632			20
21	Clerical & General Office Expenses	40,636	7,631	30,515	78,782	(7,100)	71,682	(3,855)	67,827			21
22	Employee Benefits & Payroll Taxes			294,391	294,391	20,296	314,687		314,687			22
23	Inservice Training & Education			6,260	6,260		6,260		6,260			23
24	Travel and Seminar			1,080	1,080	500	1,580		1,580			24
25	Other Admin. Staff Transportation		762	2,663	3,425		3,425		3,425			25
26	Insurance-Prop.Liab.Malpractice			25,646	25,646		25,646		25,646			26
27	Other (specify):*											27
28	**TOTAL General Administration**	150,048	13,084	407,843	570,975	20,296	591,271	(17,766)	573,505			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,185,886	444,171	582,692	3,212,749		3,212,749	(55,908)	3,156,841			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sunny Acres Nursing Home #0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			189,983	189,983		189,983		189,983			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,890	58,890		58,890	(67,374)	(8,484)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			248,873	248,873		248,873	(67,374)	181,499			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	23,105	411		23,516		23,516	(25,087)	(1,571)			40
41	Coffee and Gift Shops		5,218		5,218		5,218	(11,052)	(5,834)			41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	23,105	5,629	58,035	86,769		86,769	(36,139)	50,630			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,208,991	449,800	889,600	3,548,391		3,548,391	(159,421)	3,388,970			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,281)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,484)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(58,890)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,711)	21		18
19	Entertainment	(6,789)	17		19
20	Contributions	(522)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,600)	20		28
29	Other-Attach Schedule	(62,144)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,421)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (159,421)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Sunny Acres Nursing Home

ID# 0005009

Report Period Beginning: 12-01-00

Ending: 11-30-01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	medical supplies sold to residents	$ (24,861)	10	1
2	hair care revenues	(25,087)	40	2
3	vending machine sales	(11,052)	41	3
4	other reimbursements	(1,144)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(62,144)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 **Report Period Beginning:** 12-01-00 **Ending:** 11-30-01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,281)	0	0	0	0	0	0	0	0	0	0	(13,281)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,281)	0	0	0	0	0	0	0	0	0	0	(13,281)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(24,861)	0	0	0	0	0	0	0	0	0	0	(24,861)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(24,861)	0	0	0	0	0	0	0	0	0	0	(24,861)	16
	C. General Administration													
17	Administrative	(6,789)	0	0	0	0	0	0	0	0	0	0	(6,789)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,122)	0	0	0	0	0	0	0	0	0	0	(7,122)	20
21	Clerical & General Office Expenses	(3,855)	0	0	0	0	0	0	0	0	0	0	(3,855)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(17,766)	0	0	0	0	0	0	0	0	0	0	(17,766)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(55,908)	0	0	0	0	0	0	0	0	0	0	(55,908)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Sunny Acres Nursing Home** **#** **0005009** **Report Period Beginning:** **12-01-00** **Ending:** **11-30-01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(67,374)	0	0	0	0	0	0	0	0	0	0	(67,374)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(67,374)	0	0	0	0	0	0	0	0	0	0	(67,374)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(25,087)	0	0	0	0	0	0	0	0	0	0	(25,087)	40
41	Coffee and Gift Shops	(11,052)	0	0	0	0	0	0	0	0	0	0	(11,052)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(36,139)	0	0	0	0	0	0	0	0	0	0	(36,139)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(159,421)	0	0	0	0	0	0	0	0	0	0	(159,421)	45

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Menard County, Illinois	100	None		Countryside Estates of the County	Petersburg, Illinois	independent living facility

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Not Applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Menard County, Illinois											6
7	Tort and Liability Insurance											7
8	Fund	x		operating	$13,000.00	11-30-01	96,528	96,528	demand	none	none	8
9	TOTAL Facility Related				$13,000.00		$ 96,528	$ 96,528			$	9
	B. Non-Facility Related*											
10	Nursing Home Revenue		x	To partially finance the	$11,667.00	04-28-98	1,550,000	1,160,000	04-28-08	0.0483	58,890	10
11	Bonds			construction of an								11
12				independent living facility								12
13												13
14	TOTAL Non-Facility Related				$11,667.00		$ 1,550,000	$ 1,160,000			$ 58,890	14
15	TOTALS (line 9+line14)						$ 1,646,528	$ 1,256,528			$ 58,890	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	none	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	none	8
	1997	none	9
	1998	none	10
	1999	none	11
	2000	none	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Acres Nursing Home COUNTY Menard

FACILITY IDPH LICENSE NUMBER 0005009

CONTACT PERSON REGARDING THIS REPORT Marjorie Moritz

TELEPHONE 217-632,2334 FAX #: 217-632-2774

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	none	n/a	$ none	$ none
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ none	$ none

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? n/a YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,190 B. General Construction Type: Exterior brick Frame protected- noncombust Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Countryside Estates of the County is an independent living facility adjacent to Sunny Acres Nursing Home. The operations of Countryside Estates of the County are accounted for in a separate fund of the County. The operations of Sunny Acres Nursing Home are also accounted for in a separate Menard County fund. Menard County, through the Sunny Acres Nursing Home Fund, issued revenue bonds in April, 1998 to partially finance the construction of the facility for Countryside Estates of the County. That portion of the construction project not financed with the proceeds of the revenue bond issue was financed with funds contributed by Sunny Acres Nursing Home. The contribution from the Nursing Home to date is $1,071,628.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land that the Nursing Home is situatated is not reported as an			$	1
2	asset of the Nursing Home.				2
3	TOTALS			$	3

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58		1966	1966	$ 526,787	$ 13,170	40	$ 13,170	$	$ 441,187	4
5	38		1977	1977	568,714	14,218	40	14,218		341,231	5
6			1984	1984	61,842	2,061	30	2,061		36,071	6
7	10		1993	1993	654,160	16,354	40	16,354		133,558	7
8			1995	1995	68,999	3,450	20	3,450		20,700	8
	Improvement Type**										
9	generator			1980	28,901		10			28,901	9
10	fire alarm system			1981	9,805		10			9,805	10
11	none			1982							11
12	gazebo and floor coverings			1983	12,750	554	20-25	554		10,251	12
13	flooring,phone,and paging systems,air conditioners			1984	30,885	719	10-25	719		26,574	13
14	sun room remodelling and wallpaper			1985	7,061	143	5-30	143		5,279	14
15	kitchen remodelling, wallpaper, parking lot, nightlights,etc			1986	36,333	1,550	5-25	1,550		32,807	15
16	boiler repair,sprinkler system,office remodelling,a/c			1987	17,193	450	5-25	450		15,585	16
17	roof, chimney,carpeting,sprinkler system			1988	147,826	42,517	5-25	42,517		146,533	17
18	compressor, canopy,carport			1989	6,472	293	15-30	293		3,697	18
19	asbestos removal,flooring,water heater,landscaping,canopy			1990	28,642	1,186	5-30	1,186		15,291	19
20	main air conditioning unit			1991	5,194	346	15	346		3,663	20
21	none			1992							21
22	new lagoon,tiling,hot water heater,aviary			1993	223,851	12,800	5-30	12,800		68,902	22
23	fill old lagoon,flooring,wallpaper and painting,sign for front			1994	49,671	1,402	5-25	1,402		40,324	23
24	major boiler repair and remodelling project			1995	10,685	205	5-10	205		8,605	24
25	special needs unit, resident walking gardens,vinyl soffets			1996	139,517	6,733	5-30	6,733		40,272	25
26	donor recognition wall,remodelling,draperies,shades,moldings			1997	20,798	3,860	5-10	3,860		17,440	26
27	major boiler repair,air conditioners,ceiling tile replacement			1998	21,699	2,007	10-15	2,007		6,727	27
28	two commercial water heaters,entrybath,rooftop a/c			1999	41,844	4,747	7-10	4,747		11,868	28
29	plumbing improvements,structural enhancements			2000	18,896	6,299	3	6,299		9,448	29
30	plunbing,electrical,boiler rehab			2001	22,162	2,216	3-5	2,216		2,216	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,760,687	$ 137,280		$ 137,280	$	$ 1,476,935	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 330,381	$ 40,921	$ 40,921	$	5-20	$ 186,423	71
72	Current Year Purchases	76,805	10,507	10,507		5	10,507	72
73	Fully Depreciated Assets	258,502	1,273	1,273		5-20	258,502	73
74								74
75	TOTALS	$ 665,688	$ 52,701	$ 52,701	$		$ 455,432	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	facility operations	1993 mercury sable	1994	$ 12,925	$	$	$	3	$ 12,925	76
77	facility operations	1989 van	1989	20,735				3	20,735	77
78	facility operations	1989 van overhaul	1993	1,585				3	1,585	78
79										79
80	TOTALS			$ 35,245	$	$	$		$ 35,245	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,461,620	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 189,981	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 189,981	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,967,612	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: not applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[x]
COMMUNITY COLLEGE	[x]
HOURS PER AIDE	90

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[x]
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 1,784	$	$ 1,784
2	Books and Supplies		60	765		825
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments		276	4,145		4,421
8	Nurse Aide Competency Tests			300		300
9	TOTALS		$ 336	$ 6,994	$	$ 7,330
10	SUM OF line 9, col. 1 and 2	(e)	$ 7,330			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ none

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	22

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11-30-01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	4,208	4,208	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	241,006	366,588	3
4	Supply Inventory (priced at cost)	18,000	21,517	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): due from other funds	10,314	10,314	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 273,528	$ 402,627	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,293,782		12
13	Land			13
14	Buildings, at Historical Cost	2,760,687	5,070,196	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	700,933	782,812	16
17	Accumulated Depreciation (book methods)	(1,967,612)	(2,191,441)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		9,155	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,282)	20
21	Restricted Funds	340,752	340,752	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,128,542	$ 4,008,192	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,402,070	$ 4,410,819	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 57,770	$ 59,169	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,208	9,158	28
29	Short-Term Notes Payable	100,235	102,635	29
30	Accrued Salaries Payable	102,447	102,447	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,660	4,660	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 269,320	$ 278,069	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,160,000	1,160,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,160,000	$ 1,160,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,429,320	$ 1,438,069	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,972,750	$ 2,972,750	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,402,070	$ 4,410,819	48

***(See instructions.)**

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,644,586	1
2	Restatements (describe):		2
3			3
4	**increase in allowance for allowance accounts**	(20,000)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,624,586	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(51,836)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (51,836)	17
	B. Transfers (Itemize):		
18			18
19	**increase in contributed capital from the menard county**	400,000	19
20	**general fund**		20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 400,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,972,750	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,322,963	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,322,963	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	11,052	12
13	Barber and Beauty Care	25,087	13
14	Non-Patient Meals	13,281	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,144	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 50,564	23
	D. Non-Operating Revenue		
24	Contributions	61,324	24
25	Interest and Other Investment Income***	61,704	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 123,028	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,496,555	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	947,042	31
32	Health Care	1,694,732	32
33	General Administration	570,975	33
	B. Capital Expense		
34	Ownership	248,873	34
	C. Ancillary Expense		
35	Special Cost Centers	28,734	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,548,391	40
41	**Income before Income Taxes (line 30 minus line 40)****	(51,836)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (51,836)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,091	2,091	$ 50,307	$ 24.06	1
2	Assistant Director of Nursing	2,091	2,091	36,272	17.35	2
3	Registered Nurses	8,553	8,744	141,062	16.13	3
4	Licensed Practical Nurses	20,089	21,739	322,206	14.82	4
5	Nurse Aides & Orderlies	81,951	88,484	760,482	8.59	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,365	2,547	29,089	11.42	9
10	Activity Assistants	4,287	4,815	52,380	10.88	10
11	Social Service Workers	6,643	7,282	81,877	11.24	11
12	Dietician					12
13	Food Service Supervisor	2,091	2,091	36,469	17.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,508	9,585	92,638	9.66	15
16	Dishwashers	16,363	17,877	123,483	6.91	16
17	Maintenance Workers	3,563	3,913	41,843	10.69	17
18	Housekeepers	16,559	18,206	155,947	8.57	18
19	Laundry	7,678	8,490	56,293	6.63	19
20	Administrator	1,882	1,882	49,845	26.49	20
21	Assistant Administrator	1,882	1,882	34,923	18.56	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,376	3,810	40,636	10.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	4,094	4,855	55,490	11.43	30
31	Medical Records					31
32	Other Health Care(specify)	1,638	1,895	24,644	13.00	32
33	Other(specify)	2,108	2,263	23,105	10.21	33
34	TOTAL (lines 1 - 33)	197,812	214,542	$ 2,208,991 *	$ 10.30	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	14	$ 597	1	35
36	Medical Director	130	6,177	9	36
37	Medical Records Consultant	12	283	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,303	10	39
40	Physical Therapy Consultant	5	469	10a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	36	1,836	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	209	$ 10,665		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	36	$ 1,435	10	50
51	Licensed Practical Nurses	1,063	24,407	10	51
52	Nurse Aides	100	2,217	10	52
53	TOTAL (lines 50 - 52)	1,199	$ 28,059		53

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marjorie Moritz	administrator	0	$ 49,845
Deanna Wagner	assistant administrator	0	34,923
Diane Willing	quality assurance	0	24,644
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 109,412

B. Administrative - Other

Description	Amount
employee recognition and awards	$ 6,789
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 6,789

C. Professional Services

Vendor/Payee	Type	Amount
Michael J. Feriozzi	audit and accounting	$ 23,000
Administrative Services	cafeteria plan management	3,345
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 26,345

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,213
Unemployment Compensation Insurance	29
FICA Taxes	161,048
Employee Health Insurance	50,921
Employee Meals	20,296
Illinois Municipal Retirement Fund (IMRF)*	21,180
TOTAL (agree to Schedule V, line 22, col.8)	$ 314,687

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 159
Advertising: Employee Recruitment	6,795
Health Care Worker Background Check	600
(Indicate # of checks performed 50)	
Less: Public Relations Expense	(522)
Non-allowable advertising	( )
Yellow page advertising	6,600
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,632

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	500
Seminar Expense	1,080
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,580

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-00 Ending: 11-30-01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	none		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 **Report Period Beginning:** 12-01-00 **Ending:** 11-30-01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **life services of illinois $4,352**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,845** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **no** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **58,035**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **n/a**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **20,296** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **13,281**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **50%**
d. Have vehicle usage logs been maintained? **no**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **none**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Michael J. Feriozzi** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **in process will be provided at a later d**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.

Sunny Acres Nursing Home of Menard County
#000509

Schedule XV, Balance Sheet

Column explanation

The consolidated presentation displays Sunny Acres Nursing Home of Menard County and the County's investment in Count

Shedule XVII, Income Statement

line 25 interest and investment income

interest income	**$ 8,484**
net income independent living facility, equity methd of accounting	**53,220**
	$ 61,704

ryside Estates of the County, an independent living facility, funded through Sunny Acres Nursing Home of Menard County.